Form 103
Revised 6/05

KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
Application for Resolution of Hearing Loss Claim
Claim No. _____

_____	**vs.**	_____
Plaintiff		**Defedant/Employer**
_____		_____
Social Security Number		**Street Address**
_____		_____
Birth Date		**City/State/Zip Code**
_____		_____
Street Address		**Insurance Carrier**
_____		_____
City/State/Zip Code		**Street Address**
_____		_____
County		**City/State/Zip Code**
_____		_____
Phone Number		**Other Defendant**
		_____
		Street Address
		_____
		City/State/Zip Code
		Reason for Joinder:
		_____
		_____
		_____
		Other Defendant
		_____
		Street Address
		_____
		City/State/Zip Code
		Reason for Joinder:
		_____
		_____

Filed:

I. Nature of Injury

1. Plaintiff states that on the _____ day of _____ 20____, he/she sustained or became disabled due to occupational hearing loss arising out of and in the course of his/her employment.

2. Plaintiff became aware of this condition on:_____

3. State the date and means by which plaintiff gave notice of the injury to employer.
_____
_____

4. Place of last exposure _____
(city) (county) (state)

5. Nature of the work in which the plaintiff was engaged at the time of exposure_____
_____
_____

6. How did exposure to the disease occur? (Describe in detail) _____
_____
_____

II. Personal Data

7. Name and address of last school attended: _____
_____

8. Highest grade completed in school: _____

9. GED awarded _____yes _____no

10. Professional or vocational degrees, certificates, or licenses: _____
_____

11. Dependents: Name Social Security Number Relationship

12. Has plaintiff previously filed for or received workers' compensation benefits? _____yes _____no;
If yes, give dates, nature of injury or disease and any award of benefits received: _____
_____
_____

III. Employment Data

13. Type of work performed at date of occupational disease: _____

14. Describe the physical requirements of plaintiff's customary job: _____
_____
_____

15. Weekly wage at date of occupational disease: _____. Attach copy of any proof of wages, such as paycheck stub, W-2, etc.

16. Has plaintiff returned to work? _____yes _____no; if yes, name and address of current employer and description of job currently being performed: _____
_____

17. Is plaintiff exposed to occupational noise in his/her current job? _____yes _____no

18. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? _____yes _____no

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 are true. This the _____ day of _____ 20____.

_____
Plaintiff's Signature

Subscribed and sworn to before me this _____ day of _____ 20____.

_____
Notary Public

My Commission expires:_____ County: _____

Prepared and submitted by:

_____
Signature/Representative for Plaintiff

_____
Title

_____
Street Address

_____
City/State/Zip

_____
Telephone Number

Instructions for
Completion of Forms 101, 102 and 103

Form 101 – Application for Resolution of Injury Claim

1. All sections of this form must be completed, and must be accompanied by the following:
   a. Form 104 (Plaintiff's Employment History)
   b. Form 105 (Plaintiff's Chronological Medical History)
   c. Form 106 (Medical Waiver and Consent)
   d. Medical report describing and supporting the injury which is the basis of the claim.
   e. Proof of Wages, including W-2's, paycheck stubs, etc.

2. All information must be typewritten.

3. File the original of this form and sufficient copies for all named defendants with the **Department of Workers' Claims,** Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601.

4. If you have no telephone number, please list a number at which you may be contacted.

5. If you have questions, call 1-800-554-8601.

Form 102 - Application for Resolution of Occupational Disease Claim, and Form 103 – Application for Resolution of Hearing Loss Claim

1. All sections of this form must be completed, and must be accompanied by the following:
   a. Form 104 (Plaintiff's Employment History)
   b. Form 105 (Plaintiff's Chronological Medical History)
   c. Form 106 (Medical Waiver and Consent)
   d. Medical report supporting the occupational disease
   e. Proof of Wages, including W-2's, paycheck stubs, etc.
   f. Social Security earnings record release form.

2. This form may be filed in combination with an Application for Resolution of Injury Claim (Form 101) if both benefits are sought. Information provided should be current through the date application is signed by plaintiff.

3. All information must be typewritten.

4. File the original of this form and sufficient copies for all named defendants with the **Department of Workers' Claims**, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601.

5. If you have questions, call 1-800-554-8601.

Note: Special attention should be given to stating the correct name and address of the employer and insurance carrier. Otherwise, claim processing may be delayed.

Revised January 25, 2005